



## Epidemiologic Notes & Reports

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### HIGHLIGHTS OF THE AMENDED DISEASE SURVEILLANCE REGULATION 902 KAR 2:020

The administrative regulation 902 KAR 2:020 has been amended to include HIV reporting changes as required by Senate Bill 227 and to include reporting of additional diseases of public health importance. The amended regulation took effect on December 15, 2000. The threat of new or re-emerging infectious diseases, as well as the potential for bioterrorism events, necessitated the addition of several diseases to the list of reportable diseases, changes in the reporting criteria for laboratories and changes in the time periods for reporting specific diseases. Specific changes are addressed in this article, with underlined words being new terms now included in this regulation, new diseases or diseases listed in a new location. A revised "Reportable Diseases/Conditions in Kentucky" (form Epid-200A) is included as a removable insert in this publication.

**Section 1(4).** The reporting professional shall furnish (a) name, birthdate, address, county of residence, and telephone number of the patient; and (b) clinical, epidemiologic, and laboratory information pertinent to the disease.

**Section 1(5)(a).** number 2, [Local health department in which the laboratory is located, if that local health department is agreeable to distribute reports on residents of other jurisdictions] has been deleted. Laboratories now shall (a) report results to the (1) local health department serving the jurisdiction in which the patient resides or (2) the Department for Public Health, and (b) include in the report: name, birthdate, address, and county of residence; and (c) except for a pregnant woman, or a child born after 1992, the provisions of this subsection shall not apply to Hepatitis B.

**Section 2** Diseases requiring urgent notification

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within twenty-four (24) hours, a number of diseases have been added to the list. New additions are underlined: anthrax, botulism, brucellosis, campylobacteriosis, cryptosporidiosis, cholera, diphtheria, Escherichia coli O157:H7, Escherichia coli, shiga toxin positive, California group encephalitis, eastern equine encephalitis, St. Louis encephalitis, Venezuelan equine encephalitis, western equine encephalitis, West Nile virus encephalitis, Hansen's disease, hantavirus infection, Hemophilus influenzae invasive disease, hepatitis A, listeriosis, measles, meningococcal infections, pertussis, plague, poliomyelitis, psittacosis, Q fever, animal rabies, human rabies, rubella, congenital rubella syndrome, salmonellosis, shigellosis, syphilis, primary, secondary, early latent or congenital, tetanus, tularemia, typhoid fever, Vibrio parahaemolyticus, Vibrio vulnificus and yellow fever.

**Section 3** Diseases requiring priority notification, with notification to be made within one (1) business day now includes: Group A streptococcal infection, invasive, acute hepatitis B, hepatitis B infection in a pregnant woman or a child born in or after 1992, mumps, toxic shock syndrome, and tuberculosis.

**Section 4** Diseases requiring routine notification

**HIGHLIGHTS OF THE AMENDED  
DISEASE SURVEILLANCE REGULATION (continued)**

within five (5) business days includes the following: chancroid, *Chlamydia trachomatis* infection, ehrlichiosis, gonorrhea, granuloma inguinale, acute hepatitis C, histoplasmosis, lead poisoning, legionellosis, lyme disease, lymphogranuloma venereum, malaria, rabies post-exposure prophylaxis, rocky mountain spotted fever, Streptococcus pneumoniae, drug-resistant invasive disease, syphilis, other than primary, secondary, early latent or congenital, and toxoplasmosis.

**Section 5(2).** Outbreaks or unusual public health occurrences has waterborne infection added as reportable within one (1) business day in addition to foodborne infections.

**Section 6.** Laboratory surveillance. **(1)(a).** In addition to the reports required by Sections 1 through 4 of this administrative regulation, laboratory results shall be reported weekly for influenza virus isolates. **(1)(b).** The report established in paragraph (a) of this subsection shall include the: 1) Name, birth date, address, and county of residence of the person with the disease; and 2) specific laboratory information pertinent to the result. **(1)(c).** The format of the report shall be an alphabetical listing of each person for whom a report is submitted. **(2)(b).** *Streptococcus pneumoniae* has been removed because it is now reportable within five days.

With passage of Senate Bill 227 by the 2000 Kentucky General Assembly, physicians, laboratories and other health care professionals are required to report HIV cases by unique code rather than by name and maintain a log of patients' names with their unique code. According to the Regulation, the Unique Code will be a series of letters and numbers representing the patient's identity. It will include the patient's last initial, first initial, date of birth (MMDDYY), and last four digits of their social security number. An example of the Unique Code for fictitious patient John Q. Public whose birth-date is January 1, 2001, and Social Security number is 012-34-5678 is as

follows: **PJ/010101/5678**. Once the unique code (similar to the one provided) is determined, it should then be entered into a logbook to be maintained at the provider's office and be reported to the Department for Public Health. The crafting and reporting of the Unique Code along with the maintenance of the logbook are designed to provide anonymity to patients with HIV.

**Section 7.** Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) Surveillance. **(1)** Health professionals licensed under KRS Chapters 311 through 314, health facilities licensed under KRS Chapter 216B, and laboratories licensed under KRS Chapter 333, shall report: **(a)** All positive test results for HIV infection including:

1. Elisa,
2. Western Blot,
3. PCR,
4. HIV Antigen or
5. HIV Culture,

**(b)** CD4+ assays including absolute CD4+ cell counts and CD4+%,

**(c)** HIV detectable Viral Load Assays; and

**(d)** A diagnosis of AIDS that meets the definitions of AIDS established in:

1. "Adult HIV/AIDS Confidential Case Report Form"; or
2. "Pediatric HIV/AIDS Confidential Case Report Form".

**Section 7(3).** Reports for persons with HIV infection without a diagnosis of AIDS shall be identified in the following order by a Unique Identifier (UI) consisting of the persons:

- (a) Initials of last and first name;
- (b) Date of birth (using the format MMDDYY);  
and
- (c) Last (4) digits of his social security number.

**Section 7(4).** The following additional information shall be reported for persons with HIV infection without a diagnosis of AIDS:

- (a) Gender;
- (b) Race;

### HIGHLIGHTS OF THE AMENDED DISEASE SURVEILLANCE REGULATION (continued)

- (c) Risk factor, as identified by CDC;
- (d) County of Residence;
- (e) Name of facility submitting report;
- (f) Date and Type of HIV test performed;
- (g) Results of CD4+ cell counts and CD4+%;
- (h) Results of Viral load testing;
- (i) PCR, HIV culture, HIV antigen, if performed;
- (j) Results of TB testing, if available; and
- (k) HIV status of the person's partner, spouse or children.

**Section 7(5).** Reports of AIDS cases shall include the patient's full name and the information in subsection (1) through (4) of this section. And

- (a) The patient's complete address;
- (b) Opportunistic infections diagnosed; and
- (c) Date of onset of illness.

**Section 7(7).** Physicians and medical laboratories shall maintain a log with the name of the patient who tested positive and the unique identifier assigned.

**Section 8(3).** The local health department: (a) Shall investigate the report and carry out public measures for the control of communicable diseases appropriate to the condition.

The entire regulation can be accessed via internet:  
<http://www.lrc.state.ky.us/legresou/legres2.htm>  
or by request from the:

Kentucky Department for Public Health  
Division of Epidemiology and Health Planning,  
275 East Main St., Mailstop HS2C-B, Frankfort,  
KY 40621-0001

### PREVENT UNPOWERED SCOOTER-RELATED INJURIES

Injuries associated with unpowered scooters have increased dramatically since May 2000. These scooters are a new version of the foot-propelled scooters first popular during the 1950s. Most scooters are made of lightweight aluminum with small, low-friction wheels similar to those on in-line skates. They weigh <10 pounds and fold for easy portability and storage. Up to 5 million scooters are expected to be sold in 2000, an increase from virtually zero last year.

Approximately 85% of persons treated in EDs for these injuries were children aged <15 years, and 23% were aged <8 years; two thirds were male. The most common type of injury was a fracture or dislocation (29%), of which 70% were to the arm or hand. Other injuries included lacerations (24%), contusions/abrasions (22%), and strains/sprains (14%). Forty-two percent of all injuries occurred to the arm and hand, 27% to the head and face, and 24% to the leg and foot. Two persons have died while using a scooter. An adult fell and struck his head while showing his daughter how to ride the scooter. A 6-year-old boy rode into traffic and was struck by a car.

On the basis of evidence of injury prevention effectiveness for other related activities (in-line skating), the following recommendations may help prevent scooter-related injuries:

- Wear a helmet that meets the standard established by Consumer Product Safety Commission;
- Use knee and elbow pads;
- Ride scooters on smooth, paved surfaces without traffic, and avoid streets and surfaces with water, sand, gravel or dirt;
- Do not ride scooters at night; and
- Young children should not use scooters without close supervision.

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## January is Cervical Health Month!

By Patty Sewell, MPA

According to the American Cancer Society, cervical cancer is nearly 100% preventable, yet 300 new cases of cervical cancer will be detected in Kentucky during the year 2000. Every year in the United States, about 15,000 women are diagnosed with cervical cancer and 5,000 women die of the disease.

During January, women are encouraged to receive a Pap test, the routine screening test for cervical cancer, especially if they have never had one or if they are rarely screened (no test within the past 5 years) for cervical cancer. Women who are uninsured or underinsured may be eligible for free or low-cost cervical cancer screening through their local health department. For those women requiring additional follow up services, local health departments contract with community physicians to provide care. The physician and lab diagnostic fees are covered for those services by the Kentucky Women's Cancer Screening Project (KWCSPP) at Medicaid rates.

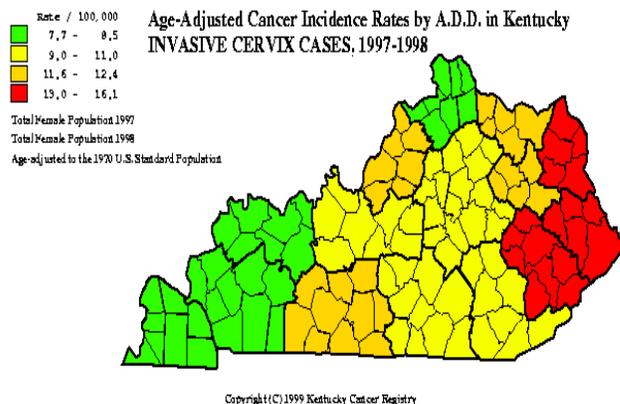
The use of the Pap test as a screening tool for cervical cancer over the past 50 years has reduced the incidence of this disease in the United States by 75 percent. Yet, despite this success, each year thousands of American women are still affected and die unnecessarily. Most of the cervical cancers that occur in the United States occur in women who have not had a Pap test within the last five years.

Experts agree that infection with certain strains of the human papillomavirus (HPV) is one of the strongest risk factors for cervical cancer. Certain sexual behaviors, including intercourse at an early age, multiple male sexual partners and sex with a male partner who has had multiple sexual partners, are also associated with greater risk for cervical cancer. Women with immunosuppressive disorders such as HIV/AIDS are considered at higher risk, as are women who fail to receive regular Pap testing and women who smoke.

The Kentucky Cancer Registry (KCR) indicates

268 cases of invasive cervical cancer in 1998, up 20 cases from 248 in 1997.<sup>1</sup> The highest age-adjusted incidence rate in Kentucky for invasive cervical cancer was in the Big Sandy Area Development District (see map below). Kentucky, as with other Southeastern states, continues to have a higher incidence of cervical cancer than other states in the nation.

A recent review was conducted of cervical cancer



in Kentucky over the past 50 years.<sup>2</sup> Within that review, data from the KCR indicated a total of 818 cases of invasive cancers diagnosed from 1995 to 1997, with an age-adjusted incidence rate of 10.99 per 100,000 women. The average age of all cases was 51 years at the time of diagnosis. Forty-six percent (46%) were over the age of 50 (average of 67 years). Historically, younger women, specifically women in child bearing years, present at the local health departments for screening. Unfortunately, many women mistakenly think they no longer need to be screened after child-bearing years. A 1998 study of "Cervical Cancer Screening Among Low-Income Women: Results of the National Screening Program, 1991-1995" published in *Obstetrics and Gynecology*, concluded that invasive cervical cancer rates are higher among older women.<sup>3</sup> Based on the Kentucky study cited above<sup>2</sup>, cervical cancer in women over age 50 years was diagnosed at a later stage than in women under the age of 50. Clearly, health care providers must do more to assure that older women continue having Pap tests.

The 1998 study published in *Obstetrics and Gynecology* also notes that cervical intraepithelial neoplasia (CIN), the precursor lesion to cervical

## January is Cervical Health Month!

cancer, is most common among younger women. It is very important that we expand our outreach to older women for Pap screening and continue our efforts with younger women as well.

The Kentucky review noted that the incidence rate of cervical cancer in African American women is higher than that of all Kentucky women, but similar to that of Appalachian women. The data showed a cervical cancer incidence rate of 10.82 per 100,000 for white women, and an incidence rate of 13.76 per 100,000 for black women. In Appalachian Kentucky, the incidence rate was 13.34 per 100,000 (Cumberland Valley, Kentucky River and Big Sandy Area Development Districts).

The Kentucky review also cited differences in staging of cervical cancer. Seventy-seven percent of the 368 cases in white women under age 50, including women in Appalachia, were local, compared to 65% of the 32 cases in black women under 50 years of age. For the 287 cases in white women over 50, 44% were initially staged as local and 56% as regional or distant. For the 23 black women over 50 years, 39% were staged as local and 61% as regional or distant. For Appalachian women over 50 years of age, 37% were local and 63% were regional or distant.

The mortality rate in African Americans was higher and survival rates in all patients revealed a "statistically significant difference between the survival rate of black women compared to that of white women, including those from Appalachian Kentucky."<sup>2</sup>

It is clear from these data that we must reach all women and their providers with messages about the importance of cervical cancer screening. C.L. Brown, also cited in the Kentucky study, stresses that emphasis must be placed on screening "older women, uninsured and impoverished women, member of ethnic minorities, particularly African-American and Hispanic women, and women residing in rural areas."<sup>4</sup> The study also suggests we must assure that all women receive adequate

treatment.

The American Cancer Society, National Cancer Institute, American College of Obstetricians and Gynecologists, American Medical Association, American Academy of Family Physicians and others recommend that annual Pap testing begin at the onset of sexual activity or at the age of 18, and should continue less frequently at the discretion of the doctor and patient after three or more annual tests have been normal. In the consideration of risk factors associated with cervical cancer, the Department for Public Health continues to provide annual Pap testing through local health departments. KCWSP funded 24,791 Pap tests in fiscal year 2000, and greater efforts must be made to assure that they reach older women and all women rarely screened.

The Department for Public Health urges all health care providers to stress the importance of getting a Pap test for all women.

1. *Kentucky Cancer Registry, 1998 Cancer Incidence Report.* Gilbert H. Friedell, M.D., Thomas C. Tucker, M.P.H., Kentucky Cancer Registry, University of Kentucky.
2. Friedell, GH., Ross, FE, Tucker, TC, et al. "Cervical Cancer in Kentucky," *Journal of the Kentucky Medical Association.* September 2000, 98, (9), 401-402.
3. Lawson, HW, Lee, NC, Thames SF, et al. "Cervical Cancer Screening Among Low-Income Women; Results From a National Screening Program, 1991-1995. *Obstetrics and Gynecology,* October 1998.
4. Brown, CL. Screening patterns for cervical cancer: How best to reach the unscreened population. JNCI Monograph No. 21, 1996;7-11.

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**RETURN SERVICE REQUESTED**

**PROVIDERS PRACTICE PREVENTION:  
A FREE PROGRAM TO INCREASE AND IMPROVE ROUTINE BREAST AND CERVICAL CANCER  
SCREENINGS.**

The Kentucky Cancer Program has developed a resource for Kentucky providers addressing Pap testing technique called **Providers Practice Prevention (PPP)**. PPP is a video self-study kit for primary care physicians, nurse practitioners, and physician assistants to increase and improve routine breast and cervical cancer screenings among Kentucky women. This free program is funded by the Centers for Disease Control and Prevention through the Kentucky Department for Public Health and is also endorsed by several Kentucky medical organizations. The program features a five-segment video including one which focuses on proper sampling and slide preparation/fixation for Pap testing.

When asked what new information practicing clinicians learned from the program, they repeatedly stated some aspect of how to perform a proper Pap test. There has been a tremendous response to the program, including requests from other states to use PPP with their providers.

For more information call: Celeste Worth 502-582-6318, at the Brown Cancer Center, Louisville.



**Reportable Diseases/Conditions in Kentucky<sup>o</sup>**  
**Cabinet for Health Services**  
**Department for Public Health**

902 KAR 2:020 requires health professionals report the following diseases to the local health department serving the jurisdiction in which the patient resides or to the Department for Public Health. (Copies of 902 KAR 2:020 available upon request.)

**I. REPORTING REQUIRED WITHIN 24 HOURS – By telephone or FAX\***

Anthrax	Encephalitis, West Nile	Rabies, animal
Botulism	<i>Haemophilus influenzae</i>	Rabies, human
Brucellosis	invasive disease	Rubella
Campylobacteriosis	Hansen's disease	Rubella syndrome, congenital
Cholera	Hantavirus infection	Salmonellosis
Cryptosporidiosis	Hepatitis A	Shigellosis
Diphtheria	Listeriosis	Syphilis, primary, secondary, early latent or congenital
<i>E. coli</i> O157:H7	Measles	Tetanus
<i>E. coli</i> , shiga toxin positive	Meningococcal infections	Tularemia
Encephalitis, California group	Pertussis	Typhoid Fever
Encephalitis, Eastern Equine	Plague	<i>Vibrio parahaemolyticus</i>
Encephalitis, St. Louis	Poliomyelitis	<i>Vibrio vulnificus</i>
Encephalitis, Venezuelan Equine	Psittacosis	Yellow Fever
Encephalitis, Western Equine	Q Fever	

**II. REPORTING REQUIRED WITHIN 1 BUSINESS DAY – By telephone or FAX\***

Foodborne outbreak	Hepatitis B, acute	Toxic shock syndrome
Hepatitis B infection in a pregnant woman or child born in or after 1992	Mumps	Tuberculosis
	Streptococcal disease Invasive, Group A	Waterborne outbreak

**III. REPORTING REQUIRED WITHIN 5 BUSINESS DAYS**

**AIDS	**HIV infection	Rocky Mountain spotted fever
Chancroid	Lead poisoning	<i>Streptococcus pneumoniae</i> , drug-resistant invasive disease
<i>Chlamydia trachomatis</i> infection	Legionellosis	Syphilis, other than primary secondary, early latent or congenital
Ehrlichiosis	Lyme disease	Toxoplasmosis
Gonorrhea	Lymphogranuloma venereum	
Granuloma inguinale	Malaria	
Hepatitis C, acute	Rabies, post exposure prophylaxis	
Histoplasmosis		

**IV. REPORTING REQUIRED BY LABORATORIES**

Diseases listed above with respective times and **weekly** reporting for **influenza virus isolates**. Upon request by the Department for Public Health, a clinical laboratory within a hospital shall report isolates and the antimicrobial resistance patterns of the isolates.

**V. REPORTING REQUIRED WITHIN 3 MONTHS**

Asbestosis	Coal worker's pneumoconiosis	Silicosis
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**VI. REPORTING OUTBREAKS OR UNUSUAL PUBLIC HEALTH OCCURRENCES**

Unusual public health occurrences should be reported promptly, with foodborne or waterborne infections or intoxications being reported within **1 business day**.

**VII. REPORTS of animal bites shall be reported to the local health department within 12 hours** in accordance with KRS 258.065.

See reverse side for **Diseases of Bioterrorism** and **reporting guidelines**.

**Diseases and Toxins Which are Possible Indicators of Bioterrorism**  
**Report Immediately**

Anthrax  
Botulism  
Brucellosis  
Mycotoxins-T2

Plague  
Q Fever  
Ricin Poisoning  
Smallpox

Staphylococcal enterotoxin B  
Tularemia  
Viral Hemorrhagic Fevers  
Viral Encephalitis-VEE

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**Reporting Guidelines**

Reports shall include:

1. The disease or condition being reported;
2. Patient's demographic information;
3. Physician's (or reporting institution's/person's) name, address and telephone number;
4. Clinical, epidemiological, and laboratory information pertinent to the disease.

**Mail reports to the local health department** or to the Department for Public Health, Division of Epidemiology and Health Planning, Mailstop HS2C-B, 275 East Main Street, Frankfort, KY 40621-0001.

**\*For additional information or to REPORT call 502-564-3418;  
1-888-9REPORT (973-7678); or FAX 502-564-0542.**

\*\*To report HIV/AIDS or obtain report forms in Louisville area – (Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, Trimble counties) call the HIV/AIDS Louisville Jefferson County Surveillance Program at 502-574-6574. In all other Kentucky counties contact the HIV/AIDS Branch at 502-564-6539.

**DO NOT REPORT AN HIV/AIDS CASE BY FAX MACHINE OR ANSWERING MACHINE.**

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